		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019976

Facility Name: The Henry and Jane Vonderlieth Living Center, Inc.

Address: 1120 North Topper Drive (Number) Mt. Pulaski (City) 62548 (Zip Code)

County: Logan

Telephone Number: (217) 792-3218 **Fax #** (217) 792-3210

IDPA ID Number: 37-0967671001

Date of Initial License for Current Owners: 10/21/1973

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 © (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Helen M. Meagher **Telephone Number:** (217) 735-2549

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Cindy Russell
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Helen M. Meagher, C.P.A.
(Firm Name & Address) Helen M. Meagher, C.P.A.
101 1/2 S. Kickapoo, Lincoln, IL 62656
(Telephone) (217) 735-2549 Fax # (217) 732-8315

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,940	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23	262		285	8
9	SNF/PED					9
10	ICF	13,048	15,975		29,023	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,071	16,237		29,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.97%

D. How many bed-hold days during this year were paid by Public Aid?
53 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/21/1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 90 and days of care provided 2,068

Medicare Intermediary Mutual of Omaha Medicare

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cen # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	235,549	17,239	6,330	259,118	(27,508)	231,610		231,610			1
2	Food Purchase		193,848		193,848	(27,339)	166,509	(4,056)	162,453			2
3	Housekeeping	65,945	25,651		91,596		91,596		91,596			3
4	Laundry	47,648	14,295		61,943		61,943		61,943			4
5	Heat and Other Utilities			116,860	116,860		116,860	(6,101)	110,759			5
6	Maintenance	72,749	16,463	32,212	121,424	2,357	123,781	(587)	123,194			6
7	Other (specify):* SEE PAGE 24			2,152	2,152		2,152		2,152			7
8	**TOTAL General Services**	421,891	267,496	157,554	846,941	(52,490)	794,451	(10,744)	783,707			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,364,894	95,207	17,286	1,477,387	(14,424)	1,462,963		1,462,963			10
10a	Therapy	38,293			38,293		38,293		38,293			10a
11	Activities	44,949	3,106	941	48,996		48,996		48,996			11
12	Social Services	23,405		3,774	27,179		27,179		27,179			12
13	Nurse Aide Training			1,924	1,924	(1,199)	725		725			13
14	Program Transportation			1,315	1,315	(125)	1,190		1,190			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,471,541	98,313	25,240	1,595,094	(15,748)	1,579,346		1,579,346			16
	C. General Administration											
17	Administrative	64,421		6,062	70,483	(2,819)	67,664	(2,976)	64,688			17
18	Directors Fees			4,802	4,802		4,802		4,802			18
19	Professional Services			34,999	34,999		34,999		34,999			19
20	Dues, Fees, Subscriptions & Promotions			11,373	11,373	1,084	12,457	(110)	12,347			20
21	Clerical & General Office Expenses	75,529	9,195	15,634	100,358		100,358		100,358			21
22	Employee Benefits & Payroll Taxes			341,146	341,146	55,318	396,464		396,464			22
23	Inservice Training & Education			1,054	1,054	31	1,085		1,085			23
24	Travel and Seminar			145	145	75	220		220			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			103,467	103,467		103,467		103,467			26
27	Other (specify):* Bad debts			15,587	15,587		15,587	(15,587)				27
28	**TOTAL General Administration**	139,950	9,195	534,269	683,414	53,689	737,103	(18,673)	718,430			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,033,382	375,004	717,063	3,125,449	(14,549)	3,110,900	(29,417)	3,081,483			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. #0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			214,558	214,558	(50,352)	164,206	7,102	171,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			214,558	214,558	(50,352)	164,206	7,102	171,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					8,313	8,313		8,313			38
39	Ancillary Service Centers		59,696	252,521	312,217	6,236	318,453		318,453			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,410	49,410		49,410		49,410			42
43	Other (specify):* SEE PAGE 24		359	20,614	20,973	50,352	71,325	(71,325)				43
44	**TOTAL Special Cost Centers**		60,055	322,545	382,600	64,901	447,501	(71,325)	376,176			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,033,382	435,059	1,254,166	3,722,607		3,722,607	(93,640)	3,628,967			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,056)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,101)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,387	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,587)	27		24
25	Fund Raising, Advertising and Promotional	(90)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (18,467)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (18,467)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Henry and Jane Vonderlieth Living Center, Inc.

ID# 0019976

Report Period Beginning: 1/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Write off prior years deferred maintenance	$ 4,720	6	1
2	Apartment expenses	(71,325)	43	2
3	Flowers	(797)	17	3
4	Investment expense	(1,179)	17	4
5	Current year deferred maintenance	(5,307)	6	5
6	Gain on sale of equipment	(285)	30	6
7	Apartment resident expense	(1,000)	17	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(75,173)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. **#** 0019976 **Report Period Beginning:** 1/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,056)	0	0	0	0	0	0	0	0	0	0	(4,056)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,101)	0	0	0	0	0	0	0	0	0	0	(6,101)	5
6	Maintenance	(587)	0	0	0	0	0	0	0	0	0	0	(587)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,744)	0	0	0	0	0	0	0	0	0	0	(10,744)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(2,976)	0	0	0	0	0	0	0	0	0	0	(2,976)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(110)	0	0	0	0	0	0	0	0	0	0	(110)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(15,587)	0	0	0	0	0	0	0	0	0	0	(15,587)	27
28	**TOTAL General Administration**	(18,673)	0	0	0	0	0	0	0	0	0	0	(18,673)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,417)	0	0	0	0	0	0	0	0	0	0	(29,417)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 **Report Period Beginning:** 1/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,102	0	0	0	0	0	0	0	0	0	0	7,102	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,102	0	0	0	0	0	0	0	0	0	0	7,102	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(71,325)	0	0	0	0	0	0	0	0	0	0	(71,325)	43
44	**TOTAL Special Cost Centers**	(71,325)	0	0	0	0	0	0	0	0	0	0	(71,325)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,640)	0	0	0	0	0	0	0	0	0	0	(93,640)	45

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cen # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Henry and Jane Vonderlieth Living Cent # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** None **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ None	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Henry and Jane Vonderlieth Living Center, Inc COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0019976

CONTACT PERSON REGARDING THIS REPORT Cindy Russell

TELEPHONE (217) 792-3218 FAX #: (217) 792-3210

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - tax exempt		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,140 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

25 apartments owned by corporation

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building and grounds	2,163,000	1971	$ 55,924	1
2					2
3	TOTALS	2,163,000		$ 55,924	3

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1973	$ 1,172,276	$ 29,307	35	$ 33,494	$ 4,187	$ 998,709	4
5	30		1977	1977	441,636	11,041	35	12,618	1,577	341,475	5
6											6
7											7
8											8
	Improvement Type**										
9	Heating system			1979	3,848		20			3,848	9
10	Conversion			1979	11,345	344	33	344		8,766	10
11	Medicine room			1981	474		20			474	11
12	Fence			1981	921		8			921	12
13	Sidewalks			1981	1,209		20			1,209	13
14	Shower room			1982	1,175	34	35	34		762	14
15	Blacktopping			1983	5,095		20			5,095	15
16	Landscaping			1984	1,000		10			1,000	16
17	Remodeling			1984	3,117	62	20	62		3,117	17
18	Parking lot			1985	36,890		15			36,890	18
19	Fire hydrant			1985	1,308		15			1,308	19
20	Building improvement			1985	5,201	173	30	173		3,351	20
21	Energy management system			1985	9,381	470	20	470		9,039	21
22	Blacktopping			1986	3,885	194	20	194		3,573	22
23	Shrubs			1986	583		10			583	23
24	Sewer lift station			1986	40,129	2,006	20	2,006		36,275	24
25	Sewer lift station			1987	15,420	771	20	771		13,814	25
26	Windows improvements			1988	4,721		5			4,721	26
27	Fan			1988	1,743		5			1,743	27
28	Office remodeling			1988	1,580		15				28
29	Sealcoating			1989	4,580	259	10		(259)	4,580	29
30	Patio door			1990	985	66	15	66		935	30
31	Trees			1990	700		10			700	31
32	Air conditioner			1991	53,731	3,582	15	3,582		48,656	32
33	Building improvements (ceilings, lift station, temperature controls			1991	16,133		10			16,133	33
34	Building improvements (kitchen floor, sprinklers, fire doors			1991	43,767	2,918	15	2,918		39,782	34
35	Fire alarm panels			1992	4,622	308	15	308		3,953	35
36	Water softener			1992	7,887		10			7,887	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Walk-in cooler	1992	$ 12,469	$ 623	20	$ 623	$	$ 7,528	37
38	Door monitor system	1992	1,700		10			1,700	38
39	30 Heating units	1992	9,810	491	20	491		6,260	39
40	Blacktopping	1992	2,859		10			2,859	40
41	Library paneling	1993	3,900	195	20	195		2,259	41
42	Convection units	1993	3,270	164	20	164		1,913	42
43	Asphalt sealcoating	1994	2,809		5			2,809	43
44	Computer room - drywall	1994	2,244	97	10	97		2,244	44
45	Pump	1994	3,439	344	10	344		3,411	45
46	Roof	1995	324,374	12,975	25	12,975		128,468	46
47	Room size heater	1995	1,604	160	10	160		1,587	47
48	Heating system units	1995	9,772	977	20	489	(488)	4,727	48
49	Garage doors	1996	1,550	155	10	155		1,305	49
50	80 Gallon water heater	1996	7,611	761	10	761		6,342	50
51	Exhaust fan	1997	1,691	169	10	169		1,183	51
52	Therapy, activity, administration offices, and additional storage	1998	796,976	22,770	35	22,770		153,698	52
53	Additional finish costs (line 52 above)	1998	4,715	135	35	135		911	53
54	Dampers and motor actuator	1998	3,293	165	20	165		1,141	54
55	Chiller	1998	14,853	743	20	743		5,139	55
56	Moveable wall	1998	9,830	393	25	393		2,456	56
57	Boiler programmer	1998	2,570	129	20	129		892	57
58	80 Gallon water heater	1998	5,287	529	10	529		3,571	58
59	Chain link fence	1999	1,019	68	15	68		374	59
60	Lowered "one head"	2000	2,087	209	10	209		923	60
61	8 Steel universal access doors 24"x24"	2000	437	44	10	44		194	61
62	11 Smoke & fire dampers	2000	21,450	2,145	10	2,145		8,938	62
63	Card zone expander installed	2000	3,185	319	10	319		1,329	63
64	Floor tile for center corridor & dining room	2000	6,290	419	15	419		1,702	64
65	Blacktopping drive (from def maint per IDPH review 2000 report)	2000	7,309		5	1,462	1,462	4,386	65
66	Boiler	2001	64,480	3,224	20	3,224		10,209	66
67	4" wall base in corridors & dining room	2001	19,200	1,280	15	1,280		3,947	67
68	12 time delayed locks on outside doors	2002	23,618	2,362	10	2,362		5,511	68
69	Boiler room hollow steel door	2002	1,233	35	35	35		99	69
70	TOTAL (lines 4 thru 69)		$ 3,272,276	$ 103,615		$ 110,094	$ 6,479	$ 1,979,314	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,272,276	$ 103,615		$ 110,094	$ 6,479	$ 1,979,314	1
2	Garage	2002	71,872	2,053	35	2,053		4,260	2
3	Driveway entrance sign	2003	1,967	131	15	131		175	3
4	West chain link fence 800'	2003	6,800	453	15	453		566	4
5	Compressor for chiller	2003	7,126	713	10	713		891	5
6	Sidewalks	2004	10,150	282	15	282		282	6
7	Asphalt near dumpster	2004	648	11	5	33	22	11	7
8	Asphalt and sealcoat	2004	13,303	443	5	1,329	886	443	8
9	Front entry doors	2004	5,405	248	20	248		248	9
10	Breaker box	2004	581	16	15	16		16	10
11	Receptacles in dining room	2004	1,950	33	25	33		33	11
12	Ceiling tile	2004	3,318	138	20	138		138	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,395,396	$ 108,136		$ 115,523	$ 7,387	$ 1,986,377	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 410,568	$ 39,138	$ 39,138	$	5-15 yrs	$ 268,581	71
72	Current Year Purchases	28,784	1,732	1,732		5-15 yrs	1,732	72
73	Fully Depreciated Assets	358,933	3,251	3,251		5-15 yrs	358,919	73
74								74
75	TOTALS	$ 798,285	$ 44,121	$ 44,121	$		$ 629,232	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient transport	2000 Chev. Supreme Bus	1999	$ 43,000	$ 7,167	$ 7,167	$	6	$ 37,627	76
77	Patient transport	2002 Olds Silhoutte	2001	28,690	4,782	4,782		6	15,541	77
78										78
79										79
80	TOTALS			$ 71,690	$ 11,949	$ 11,949	$		$ 53,168	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,321,295	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 164,206	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 171,593	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,387	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,668,777	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment land improvements	$ 89,457	$ 6,679	$ 60,286	86
87	Apartments	1,423,643	40,825	722,256	87
88	Portraits	6,000			88
89	Equipment	30,005	2,848	16,605	89
90					90
91	TOTALS	$ 1,549,105	$ 50,352	$ 799,147	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 13

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 600	$	$ 600
2	Books and Supplies		75		75
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		50		50
9	TOTALS	$	$ 725	$	$ 725
10	SUM OF line 9, col. 1 and 2 (e)	$ 725			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(6)	hrs	$	1,770	$ 96,421	$	1,770	$ 96,421	1
2	Licensed Speech and Language Development Therapist	39(6)	hrs		1,367	48,741		1,367	48,741	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(6)	hrs		1,768	102,558		1,768	102,558	4
5	Physician Care		visits		28	6,236		28	6,236	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts		1,724	59,696		1,724	59,696	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab services	39(3)				4,801			4,801	13
14	TOTAL			$	6,657	$ 318,453	$	6,657	$ 318,453	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 380,661	$	1
2	Cash-Patient Deposits	6,511		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	272,843		3
4	Supply Inventory (priced at FIFO cost)	17,167		4
5	Short-Term Investments	3,410,658		5
6	Prepaid Insurance	18,655		6
7	Other Prepaid Expenses	143		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	1,472		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,108,110	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,924		13
14	Buildings, at Historical Cost	4,660,451		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	905,979		16
17	Accumulated Depreciation (book methods)	(3,329,097)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements, at historica	237,873		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,531,130	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,639,240	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 48,150	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,511		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,972		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Patient Care Prepayments	5,244		36
37	Employee Health Insurance Withheld	31		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 199,908	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Apartment Resident Deposits	1,208,937		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,208,937	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,408,845	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,230,395	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,639,240	$	48

***(See instructions.)**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,805,099	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,805,099	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	425,296	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 425,296	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,230,395	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,481,390	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,481,390	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,150	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,150	23
	D. Non-Operating Revenue		
24	Contributions	318,920	24
25	Interest and Other Investment Income***	116,070	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 434,990	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	SEE PAGE 25	228,373	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 228,373	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,147,903	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	846,941	31
32	Health Care	1,595,094	32
33	General Administration	683,414	33
	B. Capital Expense		
34	Ownership	214,558	34
	C. Ancillary Expense		
35	Special Cost Centers	312,217	35
36	Provider Participation Fee	49,410	36
	D. Other Expenses (specify):		
37	Apartment expenses	20,973	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,722,607	40
41	**Income before Income Taxes (line 30 minus line 40)****	425,296	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 425,296	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,840	2,081	$ 54,827	$ 26.35	1
2	Assistant Director of Nursing	1,896	2,081	50,253	24.15	2
3	Registered Nurses	4,838	5,150	104,947	20.38	3
4	Licensed Practical Nurses	25,556	27,563	498,222	18.08	4
5	Nurse Aides & Orderlies	57,299	61,424	585,563	9.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,011	3,379	38,293	11.33	8
9	Activity Director	1,938	2,227	26,648	11.97	9
10	Activity Assistants	2,550	2,644	18,301	6.92	10
11	Social Service Workers	2,129	2,266	23,405	10.33	11
12	Dietician					12
13	Food Service Supervisor	2,011	2,269	29,708	13.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,676	23,185	205,841	8.88	15
16	Dishwashers					16
17	Maintenance Workers	3,911	4,329	72,749	16.81	17
18	Housekeepers	8,706	9,165	65,945	7.20	18
19	Laundry	4,533	5,017	47,648	9.50	19
20	Administrator	2,072	2,121	64,421	30.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,842	2,176	35,451	16.29	23
24	Clerical	3,514	3,717	40,078	10.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,066	5,633	71,082	12.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,388	166,427	$ 2,033,382 *	$ 12.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	146	$ 6,330	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	5	249	10(3)	38
39	Pharmacist Consultant	12	600	10(3)	39
40	Physical Therapy Consultant	5	432	10a(3)	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	72	3,774	12(3)	45
46	Other(specify)				46
47	Restorative Program Consultant	94	5,194	10a(3)	47
48					48
49	TOTAL (lines 35 - 48)	334	$ 16,579		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Russell	Administrator	0	$ 64,421
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,421

B. Administrative - Other

Description	Amount
SEE PAGE 25	$ 6,062
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 6,062

C. Professional Services

Vendor/Payee	Type	Amount
Helen M. Meagher, C.P.A.	Audit, cost report & 990	$ 6,800
Duane Morris, LLP	Legal services	24,017
Atlschuler, Melvoin, & Glasser, LLP	2003 Medicare cost report	4,182
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 34,999

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,175
Unemployment Compensation Insurance	0
FICA Taxes	150,484
Employee Health Insurance	119,108
Employee Meals	54,847
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Physicals	2,151
Employee Awards	1,465
Counseling for employee	35
Employee LPN schooling	1,199
TOTAL (agree to Schedule V, line 22, col.8)	$ 396,464

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$ 0
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,500
Advertising: Employee Recruitment	5,557
Health Care Worker Background Check	
(Indicate # of checks performed 61)	834
Facility Advertising	90
Life Services Network of IL dues	4,206
INHAA membership fee	150
CLIA lab certification fee	100
Less: Public Relations Expense	( )
Non-allowable advertising	(90)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,347

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SEE PAGE 25	220
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 220

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Generator repairs	7/96	$ 1,528	5	$ 177	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
2	Water heater mixing brd	1/97	3,892	5	780	0	0	0	0	0	0	0	0
3	Repair chiller	8/97	1,917	5	383	225	0	0	0	0	0	0	0
4	Paint & wallpaper	10/98	3,234	3	808	0	0	0	0	0	0	0	0
5	Repair walk-in freezer	9/99	1,746	5	349	349	349	234	0	0	0	0	0
6	Vinyl wall coverings	7/99	14,358	5	2,872	2,872	2,872	1,434	0	0	0	0	0
7	Chiller compressor replac	6/00	5,789	5	1,158	1,158	1,158	1,158	482	0	0	0	0
8	Repair chiller	7/02	2,975	5	0	248	595	595	595	595	347	0	0
9	Freezer repairs	6/02	2,369	5	0	237	474	474	474	474	236	0	0
10	Generator circuit load dat	4/03	2,354	5	0	0	353	471	471	471	471	117	0
11	Collapsed sewer repair	9/04	5,307	5	0	0	0	354	1,061	1,062	1,061	1,062	707
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 45,469		$ 6,527	$ 5,089	$ 5,801	$ 4,720	$ 3,083	$ 2,602	$ 2,115	$ 1,179	$ 707

Facility Name & ID Number The Henry and Jane Vonderlieth Living Center, Inc. # 0019976 Report Period Beginning: 1/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of IL - $4,206**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **26,510** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **49,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **54,847** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **3,150**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **1,326**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Helen M. Meagher, C.P.A.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

V. COST CENTER EXPENSES

A. General Services	Other
Line 7 Other:	
Hazardous Waste Removal	2,152
	$ 2,152
E. Special Cost Centers	
Line 43 Other:	
Supplies, column 2	
Supplies for apartments	$ 359
Other, column 3	
Apartment Expenses:	
Maintenance	7,736
Utilities	698
Trash Removal	914
Cable	3,243
Insurance	8,023
Auto mileage reimbursement	-
	$ 20,614

V. RECLASSIFICATOINS

	Description	To Line	From Line	Amount
1	Employee Meal Costs	22		$ 54,847
			1	(27,508)
			2	(27,339)
2	CDS copier service, time clock	6		2,357
	& PC maintenance		17	(2,357)
3	Apartment Depreciation	43		50,352
			30	(50,352)
4	Employee Background Checks	20		834
			22	(834)
5	CPR instructor fee and cards	23		31
			17	(31)
6	Employee physicals	22		126
			17	(126)
7	INHAA 2004 seminar	24		75
			17	(75)
8	Bank service charge	17		20
			22	(20)
9	Medically necessary transport	38		8,313
			10	(8,188)
			14	(125)
10	Physician services	39		6,236
			10.	(6,236)
11	LPN schooling for employee	22		1,199
			13	(1,199)
12	CLIA lab certificate fee	20		150
			17	(150)
13	INHAA membership fee	20		100
			17	(100)

XIX. SUPPORT SCHEDULES

B. Administrative - Other	Amount
Safe deposit box rent	$ 20
Investment fees (adjusted out)	1,179
Bank service charges	27
Secretary of State corporate franchise fee	5
Apartment resident expense (adjusted out)	1,000
Flowers (adjusted out)	797
Copier expense (reclassified)	1,690
PC maintenance (reclassified)	311
Time clock maintenance (reclassified)	356
Notary application fee and bond	40
IL Charity Bureau	15
Manuals and forms	57
CPR instructor fee and cards	31
CLIA lab certificate fee (reclassified)	150
Employee physicals (reclassified)	126
Memorial plates engraved	13
Fire/life safety catalog and code book	70
INHAA 2004 membership fee (reclassified)	100
INHAA 2004 seminar - administrator (reclassified)	75
TOTAL (agree to Schedule V, line 17, col. 3)	$ 6,062

G. Schedule of Travel and Seminar			
Description			Amount
In-State Travel			
			$ 0
TOTAL In-State Travel			$ 0
Seminar Expense	Date	Location	
2004 IAPA Conference	10/21-22/04	Decatur	$ 145
INHAA - Problems Are Closer Than They Appear	8/18-19/04	Bloomington	75
TOTAL (agree to Schedule V, line 24, col. 8)			$ 220

XVII. INCOME STATEMENT

E. Other Revenue	
Description	Amount
Apartment Income	$ 48,632
Net realized and unrealized gains on investments	178,731
Restitution	565
Federal 941 overpayment	106
Aluminum can recycled	44
Flu shot	10
Gain on sale of equipment	285
TOTAL Other Revenue	$ 228,373

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS

Facility/College	Amount
Lincoln Land Community College	$ 1,199
Springfield, IL	
Capital Area Career Center	725
Springfield, IL	
TOTAL Cost	$ 1,924

S